2011 Procedures Adult Criteria

Spinal Cord Stimulator (SCS) Trial Insertion (Custom) - UDOH[1, 2, 3*MDR, 4]

Created based on InterQual Subset: Spinal Cord Stimulator (SCS) Insertion
Version: InterQual® 2011

CLIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name		ID#	Phone#
	Signature		Date	

ICD-9-CM: 03.93, 86.94, 86.95, 86.96, 86.97, 86.98

INDICATIONS (choose one and see below)

☐ 100 Failed back surgery syndrome
☐ 200 Complex regional pain syndrome (CRPS)
☐ 300 Refractory angina
☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Failed back surgery syndrome **[All]**[5, 6]
- ☐ 110 Lumbar surgery by Hx **[One]**
  - ☐ 111 ≥ 2 prior surgeries at same level
  - ☐ 112 ≥ 1 prior surgery at > 1 level
  - ☐ 113 Prior spinal fusion surgery
- ☐ 120 Spinal cord compression excluded by Hx & PE[7]
- ☐ 130 Sx/findings **[Both]**
  - ☐ 131 Refractory pain[8]
  - ☐ 132 Interferes with ADLs[9]
- ☐ 140 Patient not a candidate for additional back surgery[10]
- ☐ 150 Demonstrated cognitive ability to manage stimulator[11]
- ☐ 160 Send for secondary medical review[12*MDR]

☐ 200 Complex regional pain syndrome (CRPS) **[All]**[13, 14]
- ☐ 210 Pain/burning in area by Hx
- ☐ 220 Findings of involved digit/extremity **[Two]**
  - ☐ 221 Swelling/tenderness
  - ☐ 222 Cyanotic/red/pale digit/extremity
  - ☐ 223 Increased sweating

- ☐ 224 Alteration of temperature[15]
- ☐ 225 Trophic skin changes[16]
- ☐ 226 Flexion contractures

☐ 230 Continued pain **after** Rx **[All]**[17]

- ☐ 231 Sympathetic block
- ☐ 232 OT/PT ≥ 8 wks[18]
- ☐ 233 Other Rx **[One]**[19]
  - ☐ -1 Antidepressant[20]
  - ☐ -2 Anticonvulsant[21]

☐ 240 Demonstrated cognitive ability to manage stimulator[11]

☐ 250 Send for secondary medical review[12*MDR]

☐ 300 Refractory angina **[All]**[22, 23, 24]

☐ 310 Sx/findings **[One]**

- ☐ 311 Continued Sx/findings after PCI/CABG[25]
- ☐ 312 Not remediable by PCI/CABG[25]

☐ 320 Demonstrated cognitive ability to manage stimulator[11]

☐ 330 Send for secondary medical review[26*MDR]

Notes

(1)
These criteria include the following procedure:
Dorsal Column Stimulator Insertion

(2)
McKesson consultants identify this procedure as:
Secondary Medical Review Mandatory

(3)-MDR:
This is a procedure or indication that requires secondary medical review. These criteria have been developed to provide reviewers with a basis for proactively gathering and documenting patient specific clinical information that will facilitate secondary medical review.

(4)
A spinal cord stimulator (SCS) is a battery operated device consisting of electrodes that are permanently implanted in the epidural space around the spinal cord and a neurostimulator that is usually placed in an abdominal pocket under the skin. The main unit and the electrodes are connected by a cable that is tunneled under the skin. The relative position of the electrodes, their orientation, distance from the spinal cord, and the electrical output all influence the effectiveness of the therapy which provides paresthesia to the painful area (Rushton, Disabil Rehabil 2002; 24(8): 407-415). SCS is appropriate only after failure of other pain management modalities and should not be a first-line intervention. Life threatening or major complications are uncommon but surgery may be needed for migration or incorrect placement of electrodes, battery replacement, or infection.

(5)
Recurrent pain after surgery (the "failed back") is difficult to evaluate and treat. It can occur in up to 40% of patients following back surgery. The cause of pain may not be surgically remediable (Jinkins and Van Goethem, Radiol Clin North Am 2001; 39(1): 1-29).

(6)
One prospective study compared patients with failed back syndrome who received SCS treatment with a control group maintained on medical therapy alone. The SCS group reported a 27% improvement in quality of life measures, an overall reduction in medication

usage, and a 15% increase in employment (Kumar et al., Neurosurgery 2002; 51(1): 106-115; discussion 115-116).

(7)
Spinal cord compression may present with bilateral sensory loss and motor weakness below the level of compression and is a medical emergency.

(8)-DEF:
Refractory pain can be defined as pain not responsive to treatment. Treatment can include surgery, medications (e.g., oral, injectable, topical), physical or psychological therapy, and passive modalities.

(9)
Impairment secondary to pain can affect one's ability to complete ADLs or IADLs. ADLs are considered those simple activities relating to basic self care. IADLs or role function refers to the usual activities an individual may perform each day. These may include: work related activities, child or eldercare, driving, transportation, recreation, hobbies, or home management. Functional difficulties may be related to the pain or the psychosocial symptoms associated with chronic pain such as depression, anger, anxiety, and impaired interpersonal relationships.

(10)
Chronic pain after spinal surgery should be evaluated to identify the etiology of the pathology. The pain in these circumstances may arise from a wide variety of problems ranging from residual surgical compression to undiagnosed problems. In the absence of a defined neurological source, most patients will not benefit from additional back surgery (Phillips et al., Spine 2002; 27(22): 2547-2553; discussion 2554).

(11)
Neurocognitive evaluation is important since patients are required to follow instructions regarding frequency and duration of use and in some instances, at their medical practitioner's direction, program the settings on the neurostimulator. Patients with behavioral health problems (e.g., suicidal depression, schizophrenia, personality disorders) may not be candidates for SCS. A candidate who is deemed unacceptable for implantation due to psychological issues may be an acceptable candidate after treatment of their psychological disorder (Doleys, Neurosurg Clin N Am 2003; 14(3): 409-417).

(12)-MDR:
Although studies show positive correlations between the use of SCS and reduction in pain, improvement in quality of life, and reduction in medication usage, treatment with SCS has not been extensively tested under the rigorous conditions of well-designed, randomized controlled trials (Taylor, J Pain Symptom Manage 2006; 31(4 Suppl): S13-19). Therefore, all requests for SCS require secondary medical review.

(13)-DEF:
Complex regional pain syndrome is a reclassification of reflex sympathetic dystrophy and causalgia. Complex regional pain syndrome has been subdivided into two types, Type I and Type II (Albazaz et al., Ann Vasc Surg 2008; 22(2): 297-306).
• Complex Regional Pain Syndrome I: Symptoms (burning pain, hyperalgesia, temperature change, skin color changes, trophic changes, localized swelling, motor dysfunction, sensory paresthesias) usually after trauma, without an overt nerve injury. Motor symptoms can include stiffness, dystonic movements, posturing, myoclonic jerks, tremor, and weakness. Pain is not confined to a single peripheral nerve distribution.
• Complex Regional Pain Syndrome II or causalgia: A regional pain syndrome, characterized by intense, continuous, burning pain and hyperalgesia that usually develops after nerve injury. The pain may spread outside the nerve distribution over time.

(14)
One study evaluated SCS for patients with CRPS. The SCS treatment group reported an 11% improvement in their quality of life primarily due to a decrease in pain. Many of the subjects were disabled at the beginning of the study due to muscle atrophy and joint contractures. Treatment with SCS did not have an impact on these problems (Kemler et al., N Engl J Med 2000; 343(9): 618-624).

(15)
The affected digit or extremity may be cooler or warmer than the uninvolved digit or extremity. There may also be variations in temperature along the same digit or extremity.

(16)
Trophic skin changes in CRPS appear as thinning of the overlying skin, with a shiny, smooth appearance.

(17)
Physical rehabilitation is performed concurrently with pharmacotherapy and should be implemented early in the course of treatment (Teasdall et al., Clin Sports Med 2004; 23(1): 145-155). Sympathetic block may be considered when the pain relief from medical therapy is inadequate to allow OT or PT (Stanton-Hicks et al., Pain Practice 2002; 2(1): 1-16).

(18)
Early OT or PT after diagnosis is essential to recovering or preserving limb function (Chen et al., Mayo Clin Proc 2004; 79(12): 1533-1545).

(19)
Other agents used in the treatment of CRPS include opioids, bisphosphonates, calcium channel blockers (e.g., nifedipine), alpha-agonists (e.g., topical clonidine), and topical capsaicin; however, studies have shown conflicting evidence of effectiveness (Chen et al., Mayo Clin Proc 2004; 79(12): 1533-1545; Cepeda et al., Clin J Pain 2002; 18(4): 216-233).

(20)
TCAs such as amitriptyline, nortriptyline, and doxepin are considered first-line agents for reducing neuropathic pain associated with CRPS (Rho et al., Mayo Clin Proc 2002; 77(2): 174-180).

(21)
Anticonvulsants (e.g., gabapentin, phenytoin, carbamazepine) have multiple modes of action and have been shown to be beneficial in reducing the neuropathic pain associated with CRPS (Chen et al., Mayo Clin Proc 2004; 79(12): 1533-1545; Cepeda et al., Clin J Pain 2002; 18(4): 216-233).

(22)-DEF:
Angina pectoris is defined as discomfort in the chest associated with myocardial ischemia. Symptoms of angina may vary from patient to patient and include sensations of pain (classically involving the chest with radiation to the left arm), choking, pressure, squeezing, tightness, heaviness, or burning. Isolated shoulder, back, neck, and jaw complaints can also be described.

(23)
Patients with refractory angina have ischemia confirmed by testing (e.g., ETT, stress echo) and symptoms so severe they experience discomfort with ordinary physical activity or have limited physical activity. These patients can be unresponsive to all conventional medical therapies, as well as revascularization surgery (Kim et al., J Am Coll Cardiol 2002; 39(6): 923-934).

(24)
Both retrospective and observational studies have shown a decrease in anginal pain with the use of SCS. The mechanism of action is not fully understood but it is hypothesized that in addition to pain blockade, there is an anti-ischemic component to the therapy. In a prospective study, patients with refractory angina who were not candidates for surgical intervention were treated with SCS. The study showed a significant improvement of anginal symptoms (Lapenna et al., Ann Thorac Surg 2006; 82(5): 1704-1708). The concern that treatment with SCS will result in increased cardiac death secondary to the masking of the clinical symptoms of MI is not supported by the data (Di Pede et al., Am J Cardiol 2003; 91(8): 951-955).

(25)-DEF:
Percutaneous coronary intervention (PCI) is the opening of a stenosed coronary vessel by means of balloon angioplasty, stent insertion, atherectomy, or combination thereof.

(26)-MDR:
Although studies show positive correlations between the use of SCS, and reduction in pain, improvement in quality of life, and reduction in medication usage, treatment with SCS has not been extensively tested under the rigorous conditions of well-designed, randomized controlled trials. Therefore, all requests for SCS require secondary medical review.